

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

Page 4

1  
13030  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13001

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Northampton</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Manokin</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Exmore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Age Home</b>		d. STREET ADDRESS <b>83X-3</b>	
3. NAME OF DECEASED (Type or print) First <b>Rosie</b> Middle <b>Badger</b> Last		4. DATE OF DEATH Month <b>Nov.</b> Day <b>20</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 19, 1884</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Harmonson</b>		14. MOTHER'S MAIDEN NAME <b>Annie Hatchett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>George Scarborough</b>	
17. INFORMANT <b>George Scarborough</b>		Address <b>Crisfield, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic GastroEnteritis</b> <b>572.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Haemorrhage</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 15<sup>th</sup> 1958</b> to <b>Nov 20<sup>th</sup> 1960</b> that (I) (we) last saw the deceased alive on <b>Nov 19<sup>th</sup> 1960</b> , and that death occurred at <b>5 p. M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Edson G. Marksman</b>		22b. DATE SIGNED <b>11-21-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edson G. Marksman</b>		22d. ADDRESS <b>Princess Ann, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 27, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Exmore, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar Wharton</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 28 '60</b>	
ADDRESS <b>New Church, Va.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Kinn</b>	

13093

CERTIFICATE OF DEATH

13093

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CERTIFICATE OF DEATH

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

13002

13031

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt Vernon				c. LENGTH OF STAY IN 1b 6 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Gertrude Middle Bowland Last				4. DATE OF DEATH Month II Day 3 Year 1960			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/10/1894	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY House Wife		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Doane				14. MOTHER'S MAIDEN NAME Martha Doane			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Madline Pinkett, MT Vernon, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH Due week 34 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept 30, 1952, to Nov 3, 1960, that I last saw the deceased alive on Sept 30, 1960, and that death occurred at 11:00 AM, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Edwin G. Markman M.D.				Princess Anne, Md			
PHYSICIAN'S NAME (Type) Edwin G. Markman				Princess Anne, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/5/60		22c. NAME OF CEMETERY OR CREMATORY ST Marks		22d. LOCATION (City, town, or county) (State) Cakville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE William H. James Jr. Princess Anne, Md				24a. REC'D BY REGISTRAR DATE NOV 9 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

13003

Reg. Dist. No.

13032

1. PLACE OF DEATH o. COUNTY <b>SOMERSET</b> M		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. LENGTH OF STAY IN 1b <b>10 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>E.W. MCCREADY MEMORIAL HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BEATRICE</b> Middle <b>MAE</b> Last <b>BUNDICK</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>27</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 26, 1890</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>WILLIAM TAYLOR</b>	
14. MOTHER'S MAIDEN NAME <b>EUGENIA KNIGHT</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>None</b>	
16. SOCIAL SECURITY NO. <b>INFORMANT</b>		Address <b>STACIUS BUNDICK MARION STATION MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Die of heart Impediment</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Chronic Art. hypert. Chronic myocarditis</b> DUE TO (c) <b>Arterio-sclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>General Arterio-sclerosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. — p. m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 17</b> , 19 <b>60</b> , to <b>Nov 27</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Nov 27</b> , 19 <b>60</b> , and that death occurred at <b>1:40 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George C. Coulbourn</b>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>GEORGE C. COULBOURN, M.D., MARION STATION, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 1, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Marion Station, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 5 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

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2000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13004

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Pocomoke City</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Pocomoke City</b>				d. STREET ADDRESS <b>R.F.D. 1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. 1</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>SIDNEY</b> Middle <b>HAROLD</b> Last <b>CAREY</b>				4. DATE OF DEATH Month <b>November</b> Day <b>30</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 18, 1929</b>	
9. AGE (In years last birthday) <b>31</b> yrs.		IF UNDER 1 YEAR Months <b>31</b> Days <b>31</b> Hours <b>31</b> Min.		IF UNDER 24 HRS. Hours <b>31</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>General Store</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Oliver Pittman Carey</b>				14. MOTHER'S MAIDEN NAME <b>Louise Mills</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>214-30-8335</b>		17. INFORMANT <b>Frederick W. Carey, Pocomoke City, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Pocomoke City, Md.</b>				(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Mar. 8, 1958</b> to <b>Nov. 30, 1960</b> , that (I) (we) last saw the deceased alive on <b>Nov. 30, 1960</b> and that death occurred at <b>5 p. M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Charles W. Trader</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12-1-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles W. Trader, M.D.</b>				22d. ADDRESS <b>302 Market St., Pocomoke City, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-3-60</b>		23c. NAME OF CEMETERY <b>First Baptist</b>		23d. LOCATION (City, town, or county) (State) <b>Pocomoke City, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harry M. Dabson</b>				ADDRESS <b>Pocomoke City, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 5 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

13000

CERTIFICATE OF DEATH

13003

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
STATE OF MASSACHUSETTS  
COUNTY OF WORCESTER  
CITY OF WORCESTER  
DECEASED  
NAME  
AGE  
SEX  
DATE OF BIRTH  
DATE OF DEATH  
PLACE OF BIRTH  
PLACE OF DEATH  
CAUSE OF DEATH  
DISEASE  
SIGNATURE OF DECEASED  
SIGNATURE OF WITNESSES  
SIGNATURE OF CLERK  
DATE OF ENTRY  
12-1-00  
Charles W. Fisher, M.D., 505 Market St., Worcester City, Mass.  
Worcester City, Worcester County, Massachusetts  
12-1-00



13034

## CERTIFICATE OF DEATH

Reg. Dist. No.

13005

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>VIRGINIA</b> b. COUNTY <b>ACCOMAC</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. LENGTH OF STAY IN 1b <b>32 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>E.W. MCCREADY MEMORIAL HOSP.</b>		d. STREET ADDRESS <b>83X-3</b>	
3. NAME OF DECEASED (Type or print) <b>EYDELLA</b> First Middle Last <b>DALEY</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>4</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-5-1898</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TANGIER, VA.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>CHARLES H CROCKETT</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH SHORES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
INFORMANT Address <b>ROSE PARKS TANGIER, VIRGINIA</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LYMPHOSARCOMA ABDOMINAL</b> 200-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to <b>Nov 4TH</b> , 19 <b>60</b> that I last saw the deceased alive on <b>Nov 4TH</b> , 19 <b>60</b> , and that death occurred at <b>12:15AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>11-4-60</b>			
ACTUAL SIGNATURE <b>Charles H. Lithgow</b> M.D.			
PHYSICIAN'S NAME (Type) <b>CHARLES H LITHGOW, MD</b>		<b>CRISFIELD, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>Nov-6-1960</b>	22c. NAME OF CEMETERY <b>WHEATLEY</b>	22d. LOCATION (City, town, or county) (State) <b>Tangier Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. J. Webster Crisfield Md</b> ADDRESS		24a. REC'D BY REGISTRAR <b>NOV 9 '60</b>	24b. REGISTRAR'S SIGNATURE <b>William S. Kline</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1303

13003

Age

Sex

Color

Married

Single

Widow

Occupation

Education

Religion

Place of Birth

Place of Death

Cause of Death

Time of Death

Signature of Physician

Signature of Registrar

Witnesses

Signature of Witnesses

Signature of Registrar

Signature of Registrar

Witnesses

Signature of Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
15M 9/59

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13035  
13006  
STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westover</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westover</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Fairmount Rd.</b>				d. STREET ADDRESS <b>Fairmount Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MANNIE</b> Middle <b>H.</b> Last <b>DENNIS</b>				4. DATE OF DEATH Month <b>November</b> Day <b>14</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 10, 1898</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm &amp; Seafood</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Arzie Dennis</b>				14. MOTHER'S MAIDEN NAME <b>Mary ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-14-4330</b>		17. INFORMANT <b>James Dennis, Westover, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Hypertension</b> (c) <b>Hypertension</b>				INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While o. m. p. m. of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 1st</b> , 19 <b>60</b> , to <b>Nov 14</b> , 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>Nov 11</b> , 19 <b>60</b> , and that death occurred at <b>7:35p</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>E. G. Marksman</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11-17-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. G. Marksman, M. D.</b>				22d. ADDRESS <b>Princess Anne, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 18, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lawsonia Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 22 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

5592

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
13036  
CERTIFICATE OF DEATH

13007

1. PLACE OF DEATH a. COUNTY <b>SOMERSET</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CRISFIELD</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EDW. W. MCCREADY MEMORIAL HOSP.</b>		e. STREET ADDRESS <b>18 ELZEY LANE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>CHARLES</b> Last <b>ELZEY</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>13</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 13, 1902</b>
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR: Months <b>58</b> Days <b>13</b> Hours <b>19</b> Min. <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES ELZEY</b>		14. MOTHER'S MAIDEN NAME <b>Maggie Roach</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-05-5929</b>	
17. INFORMANT <b>Mrs. Earl Daniel,</b> Address <b>328 Madison St., Brooklyn, N. Y.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>581 - 1 Cirrhosis Liver -</b> DUE TO <b>Alcoholism, chronic?</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Alcoholism, chronic?</b> DUE TO (c) <b>Alcoholism, chronic?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fracture, left humerus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>unknown.</b> <b>years -</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-24-1960</b> to <b>11-13-1960</b> , that (I) (we) last saw the deceased alive on <b>11-13-1960</b> , and that death occurred at <b>6P</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>C. G. Rawley.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>C. G. RAWLEY, M.D.</b>		22d. ADDRESS <b>CRISFIELD, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE THEREOF <b>Nov. 16, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lawsonia Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 18 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles L. Howard</b>			





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13008

13027

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b> c. LENGTH OF STAY IN 1b <b>Princess Anne</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Beauchamp</b> Last <b>Hill</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>26,</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 20, 1875</b>		9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>W.V. Pond Gap, W.V.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Lorenzo D. Hill</b>				14. MOTHER'S MAIDEN NAME <b>Mary Currence</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Marshall Hill, Princess Anne, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Senility and Exhaustion, Cardiac Failure</b> DUE TO <b>Gastric Ulcers</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Anorexia</b> Interval between onset and death <b>Years</b> <b>10 weeks</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R. H. Johnson</b> EXAMINER'S NAME (Type) <b>R. H. Johnson, M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/29/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Andrews Episcopal</b>		22d. LOCATION (City, town, or county) (State) <b>Princess Anne, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James L. Luman</b> ADDRESS <b>Princess Anne, Md.</b>				24a. REC'D BY REGISTRAR <b>NOV 30 60</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Luman</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13028

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13009

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Somerset</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Ellen</b> Last <b>Layfield</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>26</b> Year <b>19 60</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 10, 1872</b>	
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Augustus Harvey</b>				14. MOTHER'S MAIDEN NAME <b>Martha Clark</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Virginia Layfield, Princess Anne, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerosis</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>2-3 years</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R. H. Johnson</b> EXAMINER'S NAME (Type) <b>R. H. Johnson, M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <b>11/28/60</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/28/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Manokin Presbyterian</b>		22d. LOCATION (City, town, or county) (State) <b>Princess Anne, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James Johnson</b> ADDRESS <b>Princess Anne, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 30 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Carl L. Evans</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



13037

CERTIFICATE OF DEATH

13010

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD.</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>East Princess Anne</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>East Princess Anne</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Viola</b> Middle Last <b>Long</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>17</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 13, 1903</b>
9. AGE (In years last birthday) yrs. <b>57</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>East Princess Anne</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Miles</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Milbourne</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No.</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-28-4079</b> INFORMANT <b>Miss Viola Miles-E. Princess Anne, MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>442X</b> DUE TO <b>Hypertensive cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Arterioneophrosis of kidneys</b> (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>years</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11-8-60</b> , 19____, to <b>11-17-60</b> , 19____, that I last saw the deceased alive on <b>11-17-60</b> , 19____, and that death occurred at <b>8:15PM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Everett C. Sutter</b>		ADDRESS (Street, city or town, state) <b>Dames Quarter, Maryland</b> DATE SIGNED <b>11-18-60</b>	
PHYSICIAN'S NAME (Type) <b>Everett C. Sutter MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 20 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oakeville</b>	22d. LOCATION (City, town, or county) (State) <b>East Princess Anne, Som. Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. Ward-Marion</b>		24a. REC'D BY REGISTRAR <b>NOV 28 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

*(continued)*

1974

11-17-80  
8:15 PM

00-8-1

08-71-11



## CERTIFICATE OF DEATH

Reg. Dist. No.

13011

13029

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>Mt. Vernon Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Jennie D. Smullin</b>		4. DATE OF DEATH Month <b>November</b> Day <b>14</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 16, 1888</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Stephen Pilchard</b>		14. MOTHER'S MAIDEN NAME <b>Mary Francis Scott</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>John Smullin</b> Address <b>Princess Anne, Md.</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of uterus</b> <b>174X</b> DUE TO <b>with generalized metastasis</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-11-57</b> , 19__, to <b>11-14-60</b> , 19__, that I last saw the deceased alive on <b>11-14-60</b> , 19__, and that death occurred at <b>1:30PM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Everett C. Sutter</b>		ADDRESS (Street, city or town, state) <b>Dames Quarter, Maryland</b> DATE SIGNED <b>11-15-60</b>	
PHYSICIAN'S NAME (Type) <b>Everett C. Sutter MD</b>		M.D. <b>Dames Quarter, Maryland</b>	
22a. BURIAL, CREMATION, (Specify) <b>burial</b>		22b. DATE THEREOF <b>11/16/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Andrews</b>		22d. LOCATION (City, town, or county) (State) <b>Princess Anne, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James L. Linn</b> ADDRESS <b>Princess Anne, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 22 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13829

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CERTIFICATE OF DEATH

No.

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Ernest Anne

11-11-60

11-11-60

1:30PM

11-11-60

Dames Carter, Maryland 11-11-60

Ernest C. Butterfield

Ernest Anne

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Ernest Anne

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
13026  
CERTIFICATE OF DEATH

13012

1. PLACE OF DEATH o. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Office, Dr. Sarah M. Peyton</b>				d. STREET ADDRESS <b>110 Locust St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>GORDON</b> Middle <b>RICHARD</b> Last <b>STERLING</b>				4. DATE OF DEATH Month <b>November</b> Day <b>2</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 17, 1912</b>	
9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months <b>48</b> Days <b>48</b> Hours <b>48</b> Min.		IF UNDER 24 HRS. Months <b>48</b> Days <b>48</b> Hours <b>48</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Bakery Products</b>		11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Gordon R. Sterling</b>				14. MOTHER'S MAIDEN NAME <b>Mary Tyler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>				16. SOCIAL SECURITY NO. <b>215-05-5401</b>		17. INFORMANT Address <b>Mrs. Dorothy B. Sterling, Crisfield, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <b>Nov</b> Day <b>2</b> Year <b>1960</b> Hour <b>9</b> o. m. <b>00</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 2</b> 19 <b>60</b> , to <b>Nov 2</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Nov 2</b> 19 <b>60</b> , and that death occurred at <b>9:00</b> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Sarah M. Peyton</b>				22b. ADDRESS <b>33 W. Main St., Crisfield, Maryland</b>		22c. DATE SIGNED <b>NOV 9 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Sarah M. Peyton, M. D.</b>				22d. ADDRESS <b>33 W. Main St., Crisfield, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 6, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>				25a. REC'D BY REGISTRAR <b>NOV 9 1960</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hous</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13038

13013

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD, Lawsonia</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ISAAC THOMAS TYLER</b>		4. DATE OF DEATH <b>November 8 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 31, 1885</b>
9. AGE (In years lost birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Packer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Benton Tyler</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Jane Lawson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>214-32-7071</b>	
17. INFORMANT <b>Mrs. Carrie M. Tyler, Lawsonia, Crisfield, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hr.</b> <b>1 yr.</b> <b>7 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 8 1960</b> to <b>Nov 8 1960</b> , that (I) (we) last saw the deceased alive on <b>Nov 8 1960</b> and that death occurred at <b>3:00 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Sarah M. Peyton</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Sarah M. Peyton, M. D.</b>		22d. ADDRESS <b>33 W. Main St., Crisfield, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 11, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 16 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

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155-156